

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0017444	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 08/07/2024
NAME OF PROVIDER OR SUPPLIER MY PLACE OF IXONIA I		STREET ADDRESS, CITY, STATE, ZIP CODE N8616A NORTH RD IXONIA, WI 53036		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	INITIAL COMMENTS On 08/07/2024, the Bureau of Assisted Living, Southern Regional Office, conducted a verification visit at My Place of Ixonia I, an adult family home (AFH) located in Ixonia, WI. As a result of the survey, 0 deficiencies were identified. Both deficiencies from Statement of Deficiency (SOD) LY5K11 were corrected. Under statutory provisions of Wis. Stat. Chapter 50, a \$200 revisit fee is being assessed. Census: 4	M 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE